CHAPTER V

BILLING INSTRUCTIONS

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REIMBURSEMENT FOR INITIAL PRE-ADMISSION SCREENINGS

A $100.00 fee per pre-admission screening will be paid to acute-care hospitals, private psychiatric hospitals and the local Screening Committees. For the local Committees, the local health departments will receive $69.00 per screening, and the local social services departments will receive $31.00 per screening in which they participate. These fees were established as a result of the interdisciplinary committee approach and the cost associated with the registered nurse, social worker, and physician involvement in the screening process. The same fee per screening is used statewide and represents compensation for all services rendered and completion of the forms required to authorize Medicaid payment for nursing home placement or community-based long-term care waiver services.

Each pre-admission screening package sent to the Department of Medical Assistance Services (DMAS) for reimbursement is reviewed for accuracy, completeness, and adherence to DMAS policies and procedures. An incomplete, illegible, or inaccurate package will not be processed for payment. Reimbursement will be made only for a screening which includes all the required forms that have been correctly completed and submitted to DMAS. The Nursing Home Pre-Admission Screening Missing Information form in Appendix D notes some of the errors that cause reimbursement denials or delays, or both, and return of incomplete or incorrect forms to the Screening Committee. Screening Committees are encouraged to review this form to assure that these errors are not repeated. Nursing home pre-admission screening forms must be submitted to DMAS within 30 days of the assessment date to assure prompt reimbursement. To expedite the reimbursement process for pre-admission screening, submit the pre-admission screening package with the contents in the following order:

DMAS-96;
DMAS-95 or UAI;
DMAS-95 MI/MR Supplemental form or DMAS-116 (if applicable);
DMAS-97, 300 or 113B (if applicable);
DMAS-20 (consent form);
The Decision Letter; and
All Other Forms.

No additional reimbursement will be paid for updating the assessment during the same pre-admission screening process. For example, if an individual is in an acute-care hospital and a nursing facility pre-admission screening is required, the hospital will be reimbursed for only one pre-admission screening per hospital admission. There will be no reimbursement for screenings received by DMAS 12 months or more after the date of the completion of the screening.

REIMBURSEMENT FOR ALF TARGETED CASE MANAGEMENT SERVICES

There are two types of Medicaid-funded case management services for Auxiliary Grant residents in ALFs:

1. Twelve-month reassessment only; or
2. Ongoing targeted ALF case management.

It is believed that most of the Auxiliary Grant residents of ALFs will only need the required twelve-month reassessment and not ongoing targeted case management services. Ongoing Medicaid-Funded Targeted ALF Case Management is a service provided to those Auxiliary Grant residents who are receiving residential or assisted living services and who:

1. Require coordination of multiple services, or have some problem which must be addressed to ensure the resident's health and welfare, or both; and
2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and
3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not they (ALF) are capable of providing the required coordination of services. Based upon information obtained from staff of the ALF where an individual may be placed, the entity completing the initial and/or 12 month reassessment must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The individual selects a case management agency of his or her choice in the area where he or she will reside.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 (12-90) invoice to bill DMAS for targeted case management services is T2022. These services may only be billed once per quarter per recipient.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation (FHSC):

Phone: (800) 924-6741
Fax Number: (804)-273-6797
FHSC's website: http://virginia.fhsc.com, or by mail

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

REMITTANCE VOUCHER (Payment Voucher)

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. This voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

Participating providers are encouraged to monitor reimbursement for all screenings on a regular basis. They are also encouraged to communicate with DMAS regarding the status of reimbursement, assuring that all pre-admission screenings have been received by DMAS. Questions and inquiries regarding the reimbursement status of screenings should be directed to the Facility and Home-Based Services Unit at (804) 225-4222.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact FHSC at (800)-924-6741.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will no longer be accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: http://virginia.fhsc.com.

REPLENISHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) claim form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS web site (www.dmas.virginia.gov). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

For any requests for information or questions concerning the ordering of forms, call: 1-(804)-780-0076.

INQUIRIES CONCERNING BILLING PROCEDURES

Inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to the Medicaid HELPLINE number:

(804) 786-6273	Richmond Area and Out-of-State
1-800-552-8627	In-State - Toll Free

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays.

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500. The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), Billing Invoice.

The purpose of the CMS-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (See "EXHIBITS" at the end of this chapter for a sample of the form).

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the enrollee receiving the service.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name

Locator		Instructions
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.)** **a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	CONDITIONAL	Name of Referring Physician or Other Source
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**CONDITIONAL**	**CLIA#**
20	NOT REQUIRED	Outside Lab?

Locator		Instructions
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.**
22	**CONDITIONAL**	**Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices.**
23	**CONDITIONAL**	**Prior Authorization Number - Enter the PA number for the approved service.**
24A	**REQUIRED**	**Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/99). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service - Enter the 2-digit CMS code which describes where the services were rendered.**
24C	**REQUIRED**	**Type of Service - Enter the CMS code for the type of service rendered.**
24D	**REQUIRED**	**Procedures, Services or Supplies** **CPT/HCPCS[1] - Enter the 5-character CPT/HCPCS Code which describes the procedure rendered or the service provided.**

Local Code	New Code	Modifier	Description	Rate
Z8577	S0220		Short ACR Reassessment	$25.00
Z8578	S0220	U1	Full ACR Reassessment	$75.00
Z8574	T2022		ALF Targeted Case Management Services	$75.00

[1] Providers may begin using the national billing codes for dates of service on or after June 20, 2003. For dates of service on or after January 1, 2004, national billing codes must be used. Local/national code crosswalk is available on the DMAS website.

Locator		Instructions
		Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of attached documentation.
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier (i.e., 1, 2, 3 or 4) of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. Do not enter the diagnosis code in locator 21. NOTE: Only one code is processable.**
24F	**REQUIRED**	**Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.**
24G	**REQUIRED**	**Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.**
24H	**CONDITIONAL**	**EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.** **1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services** **2 - Family Planning Service**
24I	**CONDITIONAL**	**EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**REQUIRED**	**COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.** **2 - No Other Carrier** **3 - Billed and Paid** **5 Billed no coverage. All claims submitted**

Locator		Instructions
		with a Coordination of Benefits (COB) code of 5 must have an attachment documenting one of the following: • **The Explanation of Benefits (EOB) from the primary carrier; or** • **A statement from the primary carrier that there is no coverage for this service; or** • **An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is a claim for surgery and the other coverage is dental); or** • **A statement from the provider indicating that the primary insurance has been canceled.** **Claims with no attachment will be denied.**
24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3." See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	Patient's Account Number – Up to seventeen alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered

Locator		Instructions
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.**

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number
1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim).

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong enrollee eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Enrollee not my patient
1052 Void for miscellaneous reasons
1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim).

SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter I under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary physician or on referral from the primary care physician must place the primary physician's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	**Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.**
17a	When a restricted enrollee is treated on referral from the primary physician, enter the primary physician's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

SPECIAL BILLING INSTRUCTIONS

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, CMS-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the CMS-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

EXHIBITS

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PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)